

Request for Reinstatement (Title XVI - Work Issue)

Eligible Individual: _____ **SSN:** _____

Eligible Spouse: _____ **SSN:** _____

I request reinstatement of my Supplemental Security Income (SSI) Disability benefits. I am blind or disabled and my impairment is the same as (or related to) the impairment which was the basis for my prior eligibility. I am not performing substantial gainful activity (SGA) and my medical condition prevents me from performing SGA.

I understand that I may be able to receive provisional benefits while my request for reinstatement is being decided.

I know that anyone who makes or causes to be made a false statement or representation of material fact in this request or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I affirm that all information I have given in this document is true.

_____/____/____ () _____ - _____
Signature **Date** **Telephone**

Address: _____

